Teachers Health Trust

SUMMARY OF COVERAGE

Coverage for: Retiree Plan
Plan Type: PPO

What This Plans Cover and What it Cost

- **Copayments** are fixed dollar amounts (for example $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference, (This is called **balance billing**.)
- This plan encourages you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Important Questions	Answers	Why this Matters:
What is the premium?	$374 - $818, depending upon years of service and unused sick days. To determine total cost, a rate sheet is available at www.teachershealthtrust.org.	The premium is the amount paid for health insurance. This amount is determined by your plan choice and the number of dependents you have on the plan.
What is the overall deductible?	$2,500 for Out-Of-Network Services	This is applied to services rendered by doctors that are not contracted with the Teachers Health Trust.
Are there other deductibles for specific services?	YES	250.00 calendar year deductible for those Retirees living our of the service area.
Is there an out-of-pocket limit on my expenses?	$6,600.00 per individual or $13,2000 per family for in-network services family	This is the maximum amount you will have to pay for co-payments and co-insurance for all in-network services in a calendar year.
What is not included in the out-of-pocket limit?	Services rendered by out-of-network providers	There is not an out-of-pocket maximum for services rendered by out-of-network providers.
Is there an overall annual limit on what the insurer pays?	NO	There are limits for some individual services. A complete listing of limitations is available in the plan document located at www.teachershealthtrust.org.
Does this plan use a network of providers?	Yes. See www.teachershealthtrust.org or call (702) 794-0272 for a list of participating providers.	The Teachers Health Trust contracts with different providers who agree to specific allowables for specific services. Any amount the in-network provider bills in excess of the contracted amount will be written off.
Do I need a referral to see a specialist?	NO	You may make an appointment directly with a specialist without seeing a primary care provider first.
Are there services this plan doesn't cover?	Yes. Examples are: Infertility treatment, cosmetic services, any non-medically necessary services	A complete list of exclusions and limitations can be found in the complete plan document located at www.teachershealthtrust.org

WHAT THIS PLANS COVER AND WHAT IT COST

Common Medical Event	Services You May Need	Your cost if you use a provider		Limitations and Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30	After CYD 20%	
	Specialist visit	$30	After CYD 20%	
	Other practitioner office visit	$30	After CYD 20%	
	Preventive care/screening/ immunization	$30	After CYD 20%	
If you have a test	Completed by Lab	$0	After CYD 20%	Prior Authorization Required for Genetic Testing
	Completed by doctor's office	$15	After CYD 20%	Prior Authorization Required - Out of Network
	Diagnostic Test (x-ray, blood work)	$20	After CYD 20%	
	Imaging (MRI/CT Scan)	$75	After CYD 20%	Prior Authorization Required
	Imaging (PET Scan)	$400	After CYD 20%	Prior Authorization Required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.teachershealthtrust.org	Generic Drugs Under $25	$0	After CYD 20%	
	Generic Drugs Over $25	25% up to $25	After CYD 20%	
	Preferred Brand Drugs	25%/$30-$60	After CYD 20%	
	Non-Preferred Brand Drugs	40%/$45-$90	After CYD 20%	
	Pharmacy Choice Fee	$10 per Rx	N/A	PCF is other than CVS, Wal-Mart or Sam's Club
	Generic Drugs Under $75 (Mail Order)	$0	N/A	
	Generic Drugs Over $75 (Mail Order)	$30	N/A	
	Preferred Brand Drugs (Mail Order)	$75	N/A	
	Non-Preferred Brand Drugs (Mail Order)	$115	N/A	
	Specialty drugs	Prorated	N/A	30-day increments, copayment is prorated
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center	$200	After CYD 20%	
	Physician/Surgeon Fee	$250	After CYD 20%	
	Anesthesia Fee	$150	After CYD 20%	

WHAT THIS PLANS COVER AND WHAT IT COST

Common Medical Event	Services You May Need	Your cost if you use a provider		Limitations and Exceptions
		In-Network	Out-of-Network	
If you need immediate medical attention	Emergency Room Services	$300	After CYD 20%	If you are on vacation out of the area, the deductible is waived. For emergency services benefits are paid in-network; for urgent services you pay 30% of EME and any amount in excess of EME.
	Emergency Room Service (Non-Emergency)	$400	After CYD 20%	
	Urgent care	$30	After CYD 20%	
	Ambulance	20%	20%	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 per day to $900 max per admission	After CYD 20%	Authorization Required
	Physician/surgeon fee	$250	After CYD 20%	
	Anesthesia	$150	After CYD 20%	
If you have mental health, behavioral health or substance abuse needs	Mental/Behavioral health outpatient services	$30	After CYD 20%	Authorization required after 24th visit.
	Mental/Behavioral health inpatient services	$300 per day to $900 max per admission	After CYD 20%	Annual maximum benefit of 100 days combined for inpatient medical rehabilitation, chemical dependency rehabilitation, long-term acute care, skilled nursing facility or mental health - Authorization required
	Substance use disorder outpatient services	$30	After CYD 20%	Authorization required after 24th visit
	Substance use disorder inpatient services	$300 per day to $900 max per admission	After CYD 20%	Annual maximum benefit of 100 days combined for inpatient medical rehabilitation, chemical dependency rehabilitation, long-term acute care, skilled nursing facility or mental health - Authorization required
If your are pregnant	Ultrasounds	$20	After CYD 20%	Limited to 4 per pregnancy unless done by a perinatologist
	Delivery	$300	After CYD 20%	
If you need help recovering or have other special health needs	Home health care	20%	After CYD 20%	Authorization required
	Inpatient Rehabilitation services	$300 to $900 max	After CYD 20%	Annual maximum benefit of 100 days combined for inpatient medical rehabilitation, chemical dependency rehabilitation, long-term acute care, skilled nursing facility or mental health - Authorization required
If you need help recovering or have other special health needs	Skilled nursing care - facility	$300 to $900 max	After CYD 20%	Annual maximum benefit of 100 days combined for inpatient medical rehabilitation, chemical dependency rehabilitation, long-term acute care, skilled nursing facility or mental health - Authorization required
	Durable medical equipment	20%	After CYD 20%	Authorization required for DME over $500
	Hospice service	20%	20%	Authorization required

EXCLUDED SERVICES AND OTHER COVERED SERVICES

Services Your Plan Does NOT Cover (This is not a complete list. Check you Plan Document for others.)			
Infertility Treatment	Bariatric Surgery	Cosmetic Services	See Non-covered services in the Plan Document

Other Covered Services (This is not a complete list. Check you Plan Document for others.)		
Orthotics and Prosthetics	Hearing Aids	Chiropractic Services

Your Rights to Continue Coverage:

You can keep this insurance for a specified time as long as you pay your premium unless one or more of the following happens:

- You commit fraud
- The Teachers Health Trust no longer exists
- You fail to comply with any request made or condition imposed by the Trust

For more information on COBRA continuation of coverage, refer to the Legal Notices section of the plan document at www.teachershealthtrust.org, click on plan benefits.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, you can contact 702-794-0272 or 800-432-5859.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does met the minimum value minimum standard for the benefits it provides.

Questions:

Call 702-794-0272 or 800-432-5859 Monday through Thursday from 7:00 a.m. to 5:45 p.m., and 9:00 a.m. to 11:45 a.m. on Fridays. You may also e-mail the service team at serviceteam@teachershealthtrust.org. The complete plan document is available on our web site www.teachershealthtrust.org, click on Plan Benefits.

COVERAGE EXAMPLES

About these Coverage Examples:

These examples show how this plan might cover medical care in a given situation. Use these examples to see, in general, how much financial protection you might get if covered under different plans.

This is not a cost estimator.

Do not use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care, also, will be different. See the next page for important information about these examples.

Having a Baby (normal delivery)	
Sample care costs:	
First Office Visit	$170
Radiology (4 ultrasounds)	$850
Total OB Care	$2,800
Hospital Charges (mother)	$13,000
Hospital Charges (baby)	$1,600
Anesthesia	$1,000
Circumcision	$500
Total:	$19,920
Plan Pays:	$5,500
Patient Pays:	$470

Treating Breast Cancer (lumpectomy, chemotherapy)	
Sample care costs:	
Office Visits/Procedures	$3,750
Radiology	$7,400
Laboratory	$8,550
Chemotherapy	$115,800
Hospital Services	$44,670
Wig	$200
Outpatient Surgery	$10,350
Total:	$190,720
Plan Pays:	$52,610
Patient Pays:	$1,480

Having a Hip Replacement	
Sample care costs:	
Office Visits/Procedures	$460
Radiology	$175
Laboratory	$200
Surgeon Fee	$12,600
Hospital Service	$107,600
Anesthesia	$2,800
Rehabilitation Services	$1,350
Total:	$125,185
Plan Pays:	$18,700
Patient Pays:	$835

QUESTIONS AND ANSWERS ABOUT THE COVERAGE EXAMPLES

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient received all care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious the condition is and many additional factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your **premium**, the more you will pay in out-of-pocket costs, such as **copayments**, **deductibles** and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.